**Explanation of Final 2006/07 Rates (limited to five percent cap)**

Facility-Specific Identifying Information

Columns A through E of the spreadsheet titled "2006.07 Final Rates.xls" contain identifying information for each facility. Columns include: OSHPD ID, cost report end date, the Medi-Cal provider number found on the provider's OSHPD report, the Medi-Cal provider number in the EDS paid claims active provider list that corresponds to each OSHPD ID, and facility name.

Rates by Cost Grouping

For each cost grouping, the facility's reported cost per diem is compared to the peer group benchmark per diem, and the lower of these two amounts is reimbursed. Columns F through I represent the facility-specific per diems resulting from this comparison. The reported cost per diems are located in the spreadsheet titled "2006.07 NFB cost build-up.xls"; the benchmark per diems for each peer group are located in the spreadsheet titled "2006.07 Benchmarks.xls." The peer group associated with each facility is shown in Column V and discussed in the "Other Information" section below.

Pass-Through and FRVS Per Diems

Columns J through O include per diems that are not limited to a benchmark per diem. The pass-through per diems for property tax, liability insurance, license fees, caregiver training, and the Quality Assurance fee are located in columns J, L, M, N, and O, respectively. The FRVS per diem is located in Column K.

Labor-Driven Operating Allocation

Column P contains the facility-specific labor-driven operating allocation per diem, based on eight percent of the permanent direct care and indirect care labor costs for each facility. The labor-driven operating allocation is limited to five percent of the total reimbursement rate, as calculated in Column Q. The lesser of columns P and Q is represented in Column R, the "Final Labor-Driven Per Diem."

Total AB1629 Rate Calculation (pre-five percent cap)

Column S contains the draft rate for each facility, which is the sum of the AB1629 cost groupings (Columns F + G + H + I + J + K + L + M + N + O + R). However, AB1629 indicates that each facility will not receive less than its reimbursement rate under the methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for any new state or federal mandates. For 2006/07, the only new mandate is the Quality Assurance Fee. This rate for each facility is called the hold harmless rate and is located in Column T. The greater of the hold harmless rate in Column T and the draft AB1629 rate calculated in Column S is used and is located in Column U, the "Final AB1629 Per Diem (pre-5% cap)."

**Explanation of Final 2006/07 Rates (limited to five percent cap)**

Other Information

Column V contains the peer group ID, ranging from 1 through 7, depending on the county where each facility is located. See the Peer Grouping Report on-line at http://www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm for additional information on the determination of AB1629 peer groups.

Column W contains each facility's skilled nursing Medi-Cal days based on each facility's OSHPD Report ending during calendar year 2004. Annualized skilled nursing Medi-Cal days are located in Column X. The days in Column X differ from the days in Column W only for facilities with a cost report covering more or less than twelve months.

Column Y contains an "HH" if the facility was held harmless as a result of the AB1629 methodology. Columns S and T are compared to determine if the AB1629 per diem is less than or equal to the prior system per diem as of July 31, 2005, as adjusted for new state and federal mandates.

Summary

For 2006/07, AB1629 states that the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year (as adjusted for the change in the cost to the facility to comply with the state mandate of the nursing facility quality assurance fee for the 2006/07 rate year). Columns AA through AD are used to calculate the 2005/06 weighted average Medi-Cal rate, as adjusted for state and federal mandates. The 2005/06 weighted average rate is calculated by dividing the total estimated payments in Column AD by the total annualized Medi-Cal days in Column X. The 2006/07 weighted average rate is calculated by dividing the total projected payments in Column Z by the total annualized Medi-Cal days in Column X.

When the current year's weighted average rate is projected to exceed the specified limit, AB1629 requires the Department to reduce each skilled nursing facility's projected rate for the applicable rate year by an equal percentage. The projected weighted average rate for the 2006/07 rate year is $148.59, which is less than the 2005/06 weighted average rate, as adjusted for mandates, plus five percent ($142.64 * 1.05 = $149.77). Therefore, the AB1629 rate will not be capped for the 2006/2007 rate year. Final rates are located in Column AE.